Regarding the early diagnosis of occipito-posterior positions I have but little to say. I have seldom made the diagnosis before rupture of the membranes. Afterwards, it seems useless to attempt to alter the position, except by the slight means we have to imitate the natural course of rotation of the occiput forward. This, to my mind, can be better done with the ordinary forceps than in any other method. One accustomed to the use of forceps will recognize the slightest effort of nature to rectify the position, which he can at least encourage. This he cannot safely do with the traction form of instrument. As rotation occurs after the head is well down in the pelvis, there can be no objection to applying the instruments in the superior strait. In applying the forceps, each blade should be allowed to fit itself to the head (which, in my experience, I have found to be at the sides of the pelvis) and over one or other brow and cheek and the opposite portion of the skull. If the blades are passed well over the head and they lock easily, and traction is made in the direction of the pelvic axis without undue efforts either to flexion or to extension, there will be no slipping. I have frequently removed the forceps after bringing the head well down on the perineum to give the occiput a chance to rotate, and found the head—except in one instance—recede instantly to the hollow of the sacrum, where it would remain until again brought down with the forceps. In this one instance rotation commenced before the forceps were removed, and was completed before it was possible to remove them; but they were unlocked and allowed to go as they would, and no harm was done.

The chief danger to the mother when delivery occurs is of course the danger of rupture of the perineum. To prevent laceration, one author says: "Flex the chin strongly on the sternum"; another says: "Extend the forehead." One goes so far as to recommend apylying the forceps with the pelvic curve looking backward, so as to have more force for the purpose of flexion. To my mind, we are too apt to follow great leaders without consideration. No one knows better than the operator himself what ought to be done. He should have no time to think what this or that author says. He is himself the power, and it should be "what does he say?" With his head cool, common sense will teach him far more than any book. I once asked a dentist, whom I knew to be an expert in extracting teeth, if he had any particular method in extracting any particular tooth. He answered to the effect that he did not know how he was going to extract a tooth till he had on the forceps. He then let it come the way it seemed to come easiest. The same method is applicable in the case in question. If traction be made in the pelvic axis, the forehead will sometimes seem to tend to come first. If so, favor it. Or, mayhap, the occiput may seem to have a tendency to come first. If so, favor it. The method I use to prevent rupture is to first bring the head well down on the perineum, then grasp the forcep handles with the left hand, and with the right hand reach across the perineum with thumb on one side and the fingers on the other, and press with the whole strength of my hand towards the median line. The perineum should be wiped dry, as also should the hand. In doing this the strain is greatly relieved on the median line and transferred to the outer portion of the perineum.